TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Northwest Texas Hospital

Respondent Name
Nationwide Agribusiness Insurance Co

MFDR Tracking Number
M4-16-3670-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For these causes, the Requestor asks that Medical Fee Dispute Resolution issue a Findings and Decision that NORTHWEST TEXAS HOSPITAL is entitled to reimbursement for the services discussed herein, as well as all fees, interest and any other relief to which NORTHWEST TEXAS HOSPITAL may be justly entitled."

Amount in Dispute: $32,055.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier contends that its allowances shown on the EORs are correct. The carrier contends that it has properly reviewed and paid the bill in question, as reflected on the carrier's EORs."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4 – 9, 2015	Inpatient Hospital Services	$32,055.77	$25,165.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards inpatient acute care hospital services rendered on November 4 – 9, 2015.

   The insurance carrier paid $18,359.21 and denied the remaining charges with denial reason P12 – "Workers' compensation jurisdictional fee schedule adjustment." The requestor seeks an additional payment of $32,055.77.

   The disputed services are subject to the provisions of Code 28 Texas Administrative Code §134.404(f)(1) which states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > > (A) 143 percent; unless
   > > >
   > > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

2. The Medicare facility specific amount and information regarding the calculation of Medicare IPPS payment rates may be found at www.cms.gov.

   Review of the submitted medical claim finds that the DRG code assigned to the services in dispute is 956.

   The services were provided at Northwest Texas Hospital.

   Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $23,793.55. This amount multiplied by 143% results in a MAR of $34,024.78.

3. The total recommended payment for the services in dispute is $34,024.78. The insurance carrier has paid $8,859.21. The requestor is therefore entitled to an additional payment of $25,165.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $25,165.57.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $25,165.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October , 2016
Signature	Medical Fee Dispute Resolution Officer	Date
		October , 2016
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.